Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013327	A. BUILDING: _____ B. WING _____	R 05/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATERED LIVING ASSISTED LIVING	1200 KITTYHAWK DRIVE PERU, IN 46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	INITIAL COMMENTS This visit was for the Post Survey Revisit (PSR) to the Initial State Residential Licensure Survey completed on May 1, 2014. Survey dates: May 22, 2014. Facility Number: 013327 Provider Number: 013327 AIM Number: N/A Survey team: Julie Wagoner, RN TC Lora Swanson, RN Census bed type: Residential: 13 Total: 13 Census payor type: Private: 13 Total: 13 Sample: N/A Catered Living Assisted Living was found to be in compliance in accordance with 410 IAC 16.2. in regards to the PSR to the Initial State Residential Licensure Survey. Quality Review completed on May 23, 2014 by Brenda Meredith, R.N.	{R 000}		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE